Seasonal Influenza (Flu) VaccineScreening and Consent Form 2023-2023

Section 1: Patient Information

Name (First & Last):	Health Card (OHIP) Number:	
Preferred Name:	Date of Birth:	Weight (if under 18 years old):
Gender Identity:	Gender Associated with your Health Card (for billing purposes): ☐ M ☐ F ☐ X	
Address:	Telephone:	
	Emergency Contact (Name, Phone Number, Relationship):	

Section 2: COVID-19Screening Questionnaire

Question	Yes	No	Unsure	Question	Yes	No	Unsure
Have you been fully vaccinated against COVID-19 (at least two doses)?				Have you been in contact with someone that tested **positive** for COVID-19 in the **past 14 days**?			
Has the patient been sick in the past few days? Does the patient have symptoms of COVID-19 or have a fever today*? * Symptoms of COVID-19 can include fever, new onset of cough or worsening of chronic cough, shortness of breath, difficulty breathing, sore throat, difficulty swallowing, decrease or loss of smell or taste, chills, headaches, unexplained tiredness / malaise / muscle aches, nausea / vomiting, diarrhea or abdominal pain, pink eye, or runny nose or nasal congestion without other known cause.				Have you travelled outside of the Canada within the last 14 days?			
				Are you >70years old with delirium, unexplained or increased number of falls, worsening chronic conditions?			
				In the last 10 days, have you received a **COVID Alert exposure** notification on your cell phone?			

Section 3: Influenza Screening Questionnaire

Question	Yes	No	Unsure	Question	Yes	No	Unsure
Are you **sicktoday**? (fever > 39.5°C, breathing problems, active infection)				Are you **allergic** to any medications including vaccines?			
Are you **allergic** to any of the following? Latex, thimerosal, formaldehyde, TrintonX100, neomycin, kanamycin, gentamycin, polysorbate 80, CTAB (Cetyltrimethylammonium bromide), sodium deoxycholate, sucrose				Have you ever fainted or had a serious reaction (including anaphylaxis) to any previous injection or vaccine(s)? If yes, please describe the reaction:			
				Have you had a severe reaction to **eggs** or **eggproducts**?			
Are you or do you think you might be **pregnant**?				Do you have a **new** or **changing** neurological disorder?)			
Have you had **Guillain Barré Syndrome** within 6 weeks of getting a flu shot?				Do you have **bleedinga bleeding condition** or use **bloodthinners**? (e.g. warfarin, aspirin)			

Section 5: Patient Information

I, the client, parent or guardian, have read or had explained to me information about the flu shot. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the flu shot. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and are deemed medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 911 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ **I confirm that I want to receive the seasonal influenza vaccine** *OR*

☐ **I confirm that I want my child2 years of age or older to receive the seasonal influenza vaccine**

Patient/Agent Name (& Relationship):	Patient/Agent Signature:	Date Signed:

Section 6: Pharmacy Use Only

Vaccine Lot:	**QIV Vaccine administered:**	**TIV-adj orQIV-High Dose vaccine administered:**
Expiry (MM/YYYY):	**FLUZONE Quadrivalent**(0.5 mL) (*2+ years*) ☐ DIN: 02420643 Pre-filled syringe ☐ DIN: 02432730 Multi-dose vial **FLULAVAL Tetra**(0.5 mL) (*2+ years*) ☐ DIN: 02420783Multi-dose vial **AFLURIATetra** (0.5 mL)(*5+ years*) ☐ DIN: 02473283 Pre-filled syringe ☐ DIN: 02473313 Multi-dose vial **SUPEMTEK** (0.5 mL) (indicated 18+ years) *Suggest to 50-64 years for added protection –* ***Private Supply, Requires Rx Sched. 1*** ☐ DIN: 2510936 Pre-filled syringe	**FLUZONE High-Dose Quadrivalent** (0.7mL) (*65+ years*) ☐ DIN: 02500523 Pre-filled syringe **FLUAD TIV-adjuvanted** (0.5mL) (*65+ years*) ☐ DIN: 02362384 Pre-filled syringe **OTHER:** ☐ DIN:
Date of Immunization:		
Time of Immunization:		
☐ Left arm *OR* ☐ Right arm		

PHARMACIST DECLARATION:
I confirm the above-named patient is capable of providing consent for seasonal influenza vaccine and that the seasonal influenza vaccine should be given to the patient.

Pharmacist:	License #:	Signature:	Date Signed:
ROB MODESTINO	102067		
CATHY CECCACCI	104795		
ALEX ZAKARIA	612897		
JAYMIE MAILLOUX	630737		

Section 7: Epinephrine Emergency Use Only (Recommended Dose= 0.01mg/kg; MAX 0.5mg per dose)*

Patient's Last Name:	Patient's First Name:	Patient's Date of Birth (MM/DD/YYYY)
Epinephrine 0.15 mg* Children (age 2-7): Weight: 11 to 20kg (24-45lbs) ☐ **EpiPen Junior** DIN 00578657 PIN 09857424 ☐ **Allerject** DIN 002382059 PIN 09857439 **Note: Weightis the preferred basis for dosage; use age if weight is unknown**	**Epinephrine 0.3 mg*** Children (age 7-12): Weight:21 to 45kg (46 – 100 lbs) ☐ **EpiPen Adult** DIN 00509558 PIN 09857423 ☐ **Allerject** DIN 002382067 PIN 09857440 ☐ **Emerade** DIN002458446 PIN 09858129	**Epinephrine 0.5 mg*** Adolescents (age 12+) and adults: Weight≥46kg (≥101 lbs) ☐ **Emerade** DIN 002458454 PIN 09858130

Date of Administration (MM/DD/YYYY)	Times of Epinephrine Administration 1. 2. (if needed) 3. (if needed)
Number of Doses Administered:	
Pharmacist's Name and License #:	Pharmacist Signature:
Additional Notes (any emergency measures taken, or treatments administered):	Follow-up Date (MM/DD/YYYY): Follow-up Time:

*Recommended doses from Canadian Immunization Guide https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-2-vaccine-safety/page-4-early-vaccine-reactions-including-anaphylaxis.html#t4